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	IL6001044	A. BUILDING: _____ B. WING _____	08/11/2016

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S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 77 Illinois Administrative Code 300 300.1210)6 Section 300.1210 General Requirements for Nursing and Personal Care 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. This requirement is NOT MET as evidenced by: Based on observation, interview and record review the facility failed to provide adequate supervision for 1 of 4 residents (R3) reviewed for falls in the sample of 7. This failure resulted in R3 falling and being hospitalized with a left hip fracture. Finding includes: R3's Admission Record undated, documents R3 was admitted 11/25/15 with a diagnosis of psychosis and dementia of Alzheimer type. R3's Minimum Data Set (MDS) dated 5/23/16 documents R3 is moderately impaired, is only able to stabilize with staff assistance during surface to surface transfers, requires limited assistance of one person while walking in room and has a history of falls. R3's Fall Risk Assessment dated 5/23/16	S9999	Attachment A Statement of Licensure Violations	

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documents R3 is a high risk for falls.

R3's Care Plan dated 6/20/16 documents in part, "(R3) has risk factors that require monitoring and intervention to reduce potential for self injury. Risk factors include psychoactive med use daily, confusion, agitation, sliding down in chair."

R3's Care Plan dated 7/5/16 documents, "recent fall with hip fracture (6/24/16), confusion, agitation. Transfers with assist now since readmission. No falls assessed since admission, ambulated independently with wide gait."

R3's Nurse's Note dated 6/13/16 at 12:50 AM documents, "See Situation Background Assessment Request (SBAR) form."

R3's Nurse's Note dated 6/13/16 at 10:00 AM documents, "Inter Disciplinary Team (IDT) met and reviewed recent fall. Floor was wet in front of toilet. Care plan update and new intervention."

R3's SBAR Communication Form dated 6/13/16 documents in part, "Situation: Fall (bumped back of her head). This condition, symptom, or sign has occurred before: Yes. 2. Functional Status Evaluation: Needs more assistance with Activities of Daily Living (ADL's), Weakness, Falls (One or more). 10. Neurological Evaluation: Unsteadiness. Describe symptoms or signs: gait unsteady, general weakness. Appearance: (R3) went to toilet, pulled up pants and went to get back into wheelchair and fell on buttocks. Bumped back of head on wall. No injury. Nursing Notes: (R3) Alert and oriented X3 was able to tell us she fell getting back into her wheelchair and bumped her head on wall."

R3's Care Plan dated 6/13/16 documents, "(A)

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Educate staff to monitor floor for spills when making rounds."

R3's Nurse's Note dated 6/20/16 at 11:30 PM documents, "See SBAR."

R3's SBAR Communication Form dated 6/20/16 documents in part, "Situation: Fall. This condition, symptom, or sign has occurred before: Yes 2. Functional Status Evaluation: Fall (one or more). Appearance: (R3) had ambulated over to roommates bed. Certified Nursing Assistant (CNA) and I heard a noise and ran in there. CNA saw she was falling and was able to get her in time to lower her to the floor. Nursing Notes: (R3) has no injury of complaint of pain. Was assisted up off the floor and walked to her bed. (R3) reminded to use wheelchair or walker."

R3's Care Plan Dated 6/20/16 documents, "(A) Bed alarm added to alert staff of resident getting up without assistance."

R3's Nurse's Note dated 6/21/16 at 2:15 PM documents in part, "(R3) up in room ambulating while standing in front of sink she states she lost balance and fell to her left side when asking (R3) can she move her extremities she stated (I can't move my legs it hurts too bad)."

R3's Nurse's Note dated 6/21/16 at 4:00 PM documents in part, "Hospital called related to (r/t) fall diagnosis of compression fracture (fx) of T11, T12, L1 and subcaptial fx of left femur."

R3's SBAR Communication Form dated 6/21/16 documents in part, "Situation: Fall. This condition, symptom, or sign has occurred before: Yes. Appearance: (R3) ambulated over to sink in bedroom while standing there resident lost her

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balance falling and landing on her left side. Nursing Notes: (R3) was laying on the floor until the paramedics arrived she stated she was in too much pain to be moved please send me to the hospital." There was no documentation on the SBAR that R3's personal bed alarm sounded to notify staff she was ambulating without assistance.

R3's Emergency Room Visit Report dated 6/21/16 documents in part, "91 year old female with primary history of dementia present via EMS from the Facility s/p fall. (R3) stated she slipped and fell onto concrete while holding onto a countertop. (R3) denies any preceding events. (R3) complaint of left shoulder, hip, elbow and knee pain. (R3) was given 4 morphine en route with relief. Denies being on anticoagulants. Last fell 1 week ago."

R3's Radiology Report dated 6/21/16 documents in part, "Impression: 4. Impacted left subcapital femur fracture."

R3's Nurse's Noted dated 6/22/16 at 10:00 AM documents in part, "IDT met and reviewed recent event. (R3) lost balance turning around to get walker. (R3) sent to Emergency Room (ER) to be evaluated. New intervention in place. Care plan updated."

R3's Care Pan dated 6/22/16 documents, "(A) Remove walker from room when not in use to prevent as much as possible (R3) from getting up without assistance. (A) Remove walker from room when not in use. Bed alarm in place. Re-evaluate transfer status/ADL assistance upon return."

On 8/10/18 at 8:40 AM, R3 was transferred from

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her bed to her wheelchair by E8, Unit Coordinator and E9, CNA and then independently wheeled herself over to her handsink before her bed alarm began to sound. At that time E8 stated, "Something is going on with her bed alarm."

On 8/10/16 at 9:30 AM, E2, Director of Nursing (DON) stated that on 6/21/16 R3 was standing at her sink with her walker behind her and lost her balance and fell. E2 then stated that she had a bed alarm in place and it was sounding and that is why the nurse went into R3's room and so her going down. E2 also stated that R3 fell on 6/20/16 and at that time an alarm was placed on her bed as an intervention. E2 stated she only had a chair alarm prior.

On 8/10/16 at 1:00 PM E8 stated that she was the one who found R3 on the floor on 6/21/16. She stated that she heard something come from R3's room and then she heard R3 yell out for help. E8 stated that she could not recall if R3's bed alarm was sounding but she went in because she heard her yelling out. E8 then stated that she had just noticed an issue with R3's bed alarm not working properly this morning.

On 8/10/16 at 1:35 PM E2, DON stated that the IDT form for R3's fall on 6/21/16 documents R3's alarm was in place, but she did not see anything in the investigation that the alarm was sounding previous to R3's fall.

On 8/11/16 at 11:40 AM Z1, Physician for R3, stated that he hasn't seen R3 since her hip fracture but would expect the facility to try using a low bed with a resident with frequent falls.

On 8/11/16 at 10:40 AM E1, Administrator stated that the Facilities fall investigation are part of the

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S9999	Continued From page 5 Quality Assurance process. E1 then stated that R3 has had several falls in the facility since she was admitted. The Facility's undated Fall Prevention Policy documents in part, "Policy: To provide for resident safety and to minimize injuries related to falls; decrease falls and still honor each resident's wishes/desires for maximum independence and mobility." (B) Title 77 Illinois Administrative Code 300.1410 300.1410a)e)1)2)3) Section 300.1410 Activity Program a) The facility shall provide an ongoing program of activities to meet the interests and preferences and the physical, mental and psychosocial well-being of each resident, in accordance with the resident's comprehensive assessment. The activities shall be coordinated with other services and programs to make use of both community and facility resources and to benefit the residents. e) Activity program staff shall participate in the assessment of each resident, which shall include the following: 1) Background information, including education level, cultural/social issues, and spiritual needs; 2) Current functional status, including communication status, physical functioning, cognitive abilities, and behavioral issues; and 3) Leisure functioning, including attitude toward leisure, awareness of leisure resources, knowledge of activity skills, and social interaction skills and activity interests, both current and past. This requirement is NOT MET as evidence by: Based on observation, interview, and record	S9999		

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review the facility failed to provide an activity program based on residents needs for 2 of 7 residents (R3 and R4) reviewed for activities on the dementia unit in the sample of 7 and two residents in the supplemental sample (R8 and R9).

Findings include:

1. R4's Physician's Order Sheet (POS) dated 08/01/16 documents R4 has a diagnoses of Alzheimer's Disease, Dementia, and Psychosis.
On 08/09/16 at 8:30 AM, R4 was in the dining room standing by a table. R4 was rubbing the table with circular motion. No activities were observed.
On 08/09/16 at 11:40 AM, R4 was walking up and down the hallway with a shuffling gait. R4 was pointing to the floor but nothing was seen, on the floor. No activities were observed for R4 to participate in.
On 08/09/16 at 1:20 PM , there were no activities on the unit. R4 was walking around the unit.
On 08/09/16, R4 had no documented activity assessment in the clinical record.
2. R3's POS dated 08/01/16 documents R3 has diagnoses of Psychosis, Dementia of Alzheimer's type, and Major Depressive Disorder Recurrent.
On 08/09/16 at 8:30 AM, R3 was lying in bed and no activities were observed for R3 to participate in.
On 08/09/16 at 12:30 PM, R3 was sitting in her wheelchair in the hallway, and no activities were observed for R3 to participate in.
On 08/09/16, R3 had no activity assessment in her clinical record.
3. R8's POS dated 08/01/16 documents R8 has diagnoses of Depression, Alzheimer's Disease, and Dementia.
On 08/09/16 at 8:30 AM, R8 was sitting at the

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dining room table, and there weren't any activities for R8 to participate in.
On 08/10/16 R8's activity assessment was not found in the clinical record.
4. On 08/01/16 R9's POS documents R9's has diagnoses of Major Depressive Disorder, Brief Psychotic Disorder, and, Schizophrenia.
On 08\09\16 at 8:30 AM, R9 was sitting at the dining room table staring forward, and there wasn't any activities for R9 to participate in.
On 08/09/16 at 12:30 PM, R9 was sitting in the dining area again, and there wasn't any activities for R9 to participate in.
On 08/10/16 at 1:20 PM E11, Activity Director, stated "I don't do activities on Looking Glass (dementia unit), but I will come with you show you the schedule. I don't see the schedule, so ask the coordinator, because she does the activities on looking glass."
On 08/10/16 at 1:45 PM, E8, Looking Glass Coordinator stated " I just took over as coordinator, and I took my activity training on Thursday. I don't have a schedule yet, but I am getting the activities together. I will get a schedule out."

(B)

Title 77 Illinois Administrative Code 300.3240
300.3240b)f)
Section 300.3240 Abuse and Neglect
b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act)
f) Resident as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that another resident of the long-term care facility is the perpetrator of the abuse, that resident's

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condition shall be immediately evaluated to determine the most suitable therapy and placement for the resident, considering the safety of that resident as well as the safety of other residents and employees of the facility. (Section 3-612 of the Act)

These requirements are NOT MET as evidence by:

Based on interview and record review, the facility failed to investigate an allegation of potential abuse for 2 of 7 residents (R1 and R6) reviewed for incidents of potential abuse in the sample of 7.

Findings include:

1. R1's Nurse's' Notes dated 6/17/16 at 8:00 AM documents "When this nurse entered resident room to give her morning medication resident was completely nude standing in front of roommates (R6) TV saying 'Don't I have the best body.' R1 was massaging her (R1) breasts. This nurse informed (R1) that she could not do this in front of roommate (R6). (R1) put her housecoat on and ate breakfast."

R1's Nurses' Notes dated 6/17/16 at 9:00 AM documents "Called to room per another resident-this nurse saw R1 standing by TV again nude. This nurse heard her tell roommate 'You know you want me.' Roommate (R6) left room and this nurse attempted to redirect her (R1). (R1) put on underwear and crawled into bed."

R1's Behavior Monitoring Record, dated June 2016, documents "6/16/16 at 6:00 refusing to get dressed laying on bed naked yelling at staff-not wanting CNA to make bed-standing in front of TV so (R6) roommate couldn't watch TV. Yelling at

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S9999	Continued From page 9 roommate for being on TV." On 8/10/16 at 10:18 AM, E2, Director of Nursing, DON stated she was not aware of R1's sexual behaviors towards R6 and there was no investigation. On 8/10/16 at 1:23 PM, E1, Administrator, stated she was not aware of R1's sexually inappropriate behaviors to her roommate, R6. E1 stated there is no investigation and she would expect staff to notify her immediately so she can start an investigation. The Facility's Policy "Abuse Prevention Policy" dated 11/11/11, documents "This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment, and involuntary seclusion. This facility therefore prohibits mistreatment, neglect or abuse of its residents, and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents. This will be done by: Immediately protecting residents involved in identified reports of possible abuse; Definitions: Sexual Abuse includes, but is not limited to, sexual harassment, sexual coercion, or sexual assault. IV. Internal Reporting Requirements and Identification of Allegations: Employees are required to immediately report any occurrences of potential/alleged mistreatment, neglect, and abuse of residents and misappropriation of resident property they observe or hear about or suspect to a supervisor and the administrator."	S9999		

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